MDR: M4-02-4828-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for dates of service 1-9-02 through 2-22-02.
   b. The request was received on 7-29-02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFAs
   c. EOBs and example EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 9-19-02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 9-19-02. The response from the insurance carrier was received in the Division on 10-3-02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 8-29-02.
   "1. We contacted the nearest pain management clinic that provides the same service. We are enclosing copies of EOB's provided by their office showing the current reimbursement rates for the area norm. You will see from exhibit #7 that they are being paid at a rate of $137.00 per hour in the program. This is equivalent to the amount we are billing the carrier. The facility is also non-CARF certified. 2. Other carriers are paying at a rate of $137.00/hour. You can see from the EOB's we provided that payment of

$137.00 is considered the fair and reasonable amount for our region."

2. Respondent: Letter dated 10-3-02:
"…. the (Carrier) maintains that a fair and reasonable rate of reimbursement was made for a non-CARF certified pain management program. It is the position of the (Carrier) that the fees of $92.50 for CARF facilities and $74.00 for non-CARF are deemed to be fair and reasonable for this program…."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 1-9-02 and extending through 2-22-02.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $22,194.00 for services rendered on the above dates in dispute.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $11,988.00 for services rendered on the above dates in dispute.

5. Per the Requestor's Table of Disputed Services, the amount in dispute is $10,206.00 for services rendered on the above dates in dispute.

6. The Carrier's EOBs deny additional reimbursement as "D – Duplicate Charge; M – Reduced to Fair & Reasonable; O – Upon review of your request for a reconsideration, no additional benefit is recommended at this time."

DOS	CPT or Revenue CODE	BILLED	PAID	EOB	MAR$	REFERENCE	RATIONALE:
01-09-02 01-10-02 01-11-02 01-14-02 01-15-02 01-16-02 01-17-02 01-18-02 01-21-02 01-22-02 01-23-02 01-24-02 01-28-02 01-29-02 01-30-02 01-31-02 02-01-02 02-04-02 02-05-02 02-06-02 02-08-02 02-11-02 02-12-02 02-13-02 02-14-02 02-15-02 02-19-02 02-20-02 02-21-02 02-22-02	97799-CP for all dates of service	$822.00 $685.00 $685.00 $822.00 $685.00 $959.00 $685.00 $959.00 $685.00 $822.00 $822.00 $685.00 $822.00 $685.00 $822.00 $685.00 $685.00 $822.00 $548.00 $685.00 $685.00 $822.00 $685.00 $822.00 $685.00 $685.00 $685.00 $685.00 $685.00 $685.00	$444.00 $370.00 $370.00 $444.00 $370.00 $518.00 $370.00 $518.00 $370.00 $444.00 $444.00 $370.00 $444.00 $370.00 $444.00 $370.00 $370.00 $444.00 $296.00 $370.00 $370.00 $444.00 $370.00 $444.00 $370.00 $370.00 $370.00 $370.00 $370.00 $370.00	D,M,O D,M,O	No MAR DOP	MFG: Medicine Ground Rules (II) (G); TWCC Rule 133.307 (j) (1) (G); 133.307 (g) (3) (D); 413.011 (d); 133.304 (i); CPT Descriptor	The carrier has reimbursed the provider at $74.00 per hr. for Chronic Pain Management. The Provider has billed $137.00 per hr. CPT Code 97799-CP is reimbursed at fair and reasonable. The Carrier denied the disputed services as "D,M,O". Dates of services are 1-9-02 through 2-22-02. The only denial code to be reviewed is "M". The denial codes of "D" amd "O" reflect that no additional reimbursement was recommended after reaudit. Pursuant to Rule 133.307 (g) (3) (D), the requestor must provide "…documentation that discusses, demonstrates and justifies the payment amount being sought is a fair and reasonable rate of reimbursement….". The Provider has submitted example EOBs. However, the EOBs submitted reflect service dates ranging from 8-11-00 through 11-10-00. Other example EOBs submitted reflected billed amounts billed by other providers during approximately the same timeframe. However these EOBs reflected that one unit was billed indicating the billed amount as $822.00 hourly. Therefore, it is difficult to determine how this documentation discusses, demonstrates, or justifies that the hourly rate sought represents fair and reasonable. The example EOBs reflected dates of services at least 12 months prior to the dates in dispute. The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. However, the burden is on the Provider to prove that the fees requested are fair and reasonable. In this case, the Requestor has failed to support their hourly charge. Therefore, no additional reimbursement is recommended.
Totals		$22,194.00	$11,988.00				The Requestor **is not** entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 07th day of April 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll